Transfer of Assets
Section 1115 Research & Demonstration Waiver Proposal

State of Connecticut
Department of Social Services

February 2002

Contents

Section 1
Executive Summary and Introduction

In the state of Connecticut (State) Medicaid program, when an individual applies for Medicaid coverage for long-term care (LTC) services, all of the financial transactions of the individual are reviewed for a specific period of time for improper transfer activity. Individuals who have transferred assets for less than fair market value (FMV) within the look-back period are penalized by the disallowance of Medicaid payment for LTC services for a prescribed penalty period. The penalty period begins on the first of the month in which the transfer occurs, regardless of the need for LTC assistance or the individual's living arrangement and often results in the penalty period being completed prior to the individual actually requiring LTC services.

Although the federal transfer of asset (TOA) policy was intended to treat all individuals equitably, advance planning could significantly nullify its intended purpose. The current federal TOA policy has resulted in the widespread use of estate planning to intentionally shift assets to third parties while allowing the transferors to qualify for the Medicaid payment of LTC services. Estate planning literally diverts millions of dollars that could be used to pay for LTC services and discourages individuals from seeking and purchasing LTC insurance to meet their needs for a continued quality of life. These tactics have impeded Medicaid in fulfilling its intended role as payer of last resort.

Connecticut Public Act No. 01-2 of the June 2001 Special Session requires the Commissioner of the Department of Social Services (DSS) to seek a waiver of federal law for the purpose of establishing that the TOA penalty period shall begin in the month the applicant is found otherwise eligible for Medicaid coverage of LTC services, rather than the month when the transfer of assets (TOA) occurred. This change would compel individuals to utilize non-Medicaid resources for their LTC needs. The basic premise for seeking this change is that individuals capable of funding a share of their cost of LTC services should be discouraged from intentionally shifting this fiscal responsibility to the Medicaid program.

The State has made a significant effort to encourage individuals to use LTC insurance in planning for their LTC needs. Currently, under the Connecticut Long Term Care Partnership program, residents of the State may purchase LTC insurance to protect a specified amount of their assets from being counted as part of an eligibility determination for Medicaid (Title XIX). Individuals may purchase a policy for a specific amount of coverage. Should these individuals eventually need LTC services, either at home or in a nursing home, the insurance company would pay benefits towards the cost of care. If the individual then applies for Medicaid, he or she would be allowed to retain assets up to the amount that the LTC policy paid and not have this amount count towards the Medicaid program asset limit.

In furtherance of this effort and in compliance with Public Act 01-2 of the June 2001 Special Session, the State proposes to change when a penalty period is imposed for individuals who transfer assets for less than FMV in order to qualify for Medicaid assistance; expand the look-

back period from 36 months to 60 months for real property transfers, and incorporate threshold transfer levels that would allow cumulative transfers within specified dollar and date ranges to be disregarded. The State's supposition is that these changes would compel individuals to use non-Medicaid resources, including LTC insurance and personal assets, to pay for their LTC services. Moreover, the use of thresholds will expedite the processing of Medicaid applications and alleviate the applicant's burden of documenting and substantiating every financial transaction during the look-back period. The State also acknowledges the value of revising the undue hardship provisions to provide additional safeguards to individuals with dementia and those who have been exploited.

Through this proposed Demonstration project, the behavioral changes of applicants would be evaluated with the expectation that the revised TOA policy would encourage personal responsibility and the use of LTC insurance, while also realizing substantial savings to the Medicaid program. Nursing facilities should also benefit as this Demonstration project will increase the duration and number of privately-paid periods. Additionally, the State believes that this Demonstration project could be replicated by other states as a model. Finally, this Demonstration project would provide the Centers for Medicare and Medicaid Services (CMS) with the empirical evidence needed to re-evaluate the transfer of asset rules under the State Medicaid Plan and effectuate the necessary policy changes to discourage estate planning to circumvent these rules.

Section 2
Demonstration Design

I. Introduction to Demonstration Design

Under this Demonstration project, the State is seeking a waiver of federal law to change the start date of the penalty for improper transfers of assets from the first day of the month of the transfer to the first day of eligibility for Medicaid LTC services. For improper transfers made after both Medicaid eligibility and institutionalization, the penalty date would begin on the date of transfer or the date of discovery, whichever is later. Additionally, the look-back period would be extended from the current 36 months to 60 months for real property transfers. Finally, thresholds would be incorporated to simplify both the application process and administration of the program.

Currently, the State looks back 36 months prior to the date on which the individual first applied for Medicaid assistance and required LTC services. The look-back period is extended to 60 months for certain trusts. The State must apply penalties to individuals who transfer assets for less than FMV during the prescribed look-back period unless an exception or exemption applies, e.g., transfers to certain family members (such as spouse and disabled children), transfers made that are not for the purpose of qualifying for Medicaid assistance, and situations where application of a penalty would result in a hardship. **These exceptions and exemptions would not change under this Demonstration project. Furthermore, the hardship exemption will be expanded to provide additional protections to those persons with dementia and who have been exploited.**

For example, if an individual improperly transferred assets in the amount of $67,790 (the entire $67,990 is assumed to be the penalized or uncompensated value) and the current private cost of a nursing facility is $6,779 per month, under the current federal regulations, that individual would have a penalty period of 10 months ($67,790/$6,779 = 10). The 10-month penalty would start in the month the transfer occurred. The transferor could have elected to make the asset transfer in good health, and if the transfer had occurred more than 10 months before the individual needed Medicaid to pay for LTC services, the penalty period would have been already completed. Therefore, even though the 10-month penalty was technically imposed, because the beginning date of the penalty is based on the date of transfer, the penalty would have expired prior to the application for Medicaid payment of LTC services, thereby, contravening the intent of the policy.

The basic premises for this Demonstration project are as follows:

1. Millions of dollars per year in cost savings to the State and federal government would be realized.
2. Changing the penalty date would discourage the use of estate planning to obtain Medicaid

coverage for LTC services.
3. Individuals would use assets otherwise improperly transferred to pay for the cost of LTC.
4. Enrollment in Long Term Care Partnership policies would be increased.
5. Individuals would be encouraged to purchase LTC insurance.
6. Administrative simplicity in the eligibility determination would be increased.

A. Penalty Date

The penalty period is based solely on the uncompensated value of the assets and the average cost of private nursing facility care in the State. The penalty period is calculated by dividing the **uncompensated value of the transfer** by the **average monthly cost of private nursing facility care in the State**. For example, an individual sells his house with a FMV of $150,000 to his adult child for $100,000. Here, the uncompensated value is $50,000 (i.e., the penalty would be based on the $50,000 uncompensated value and not the FMV of the asset). The penalty imposed is the withholding of payment for nursing facility or other LTC services for the penalty months. If the penalty period is less than a month, the State would pro-rate the penalty on a per diem basis. Under the Demonstration project, the penalty would only be applied when the individual would be otherwise eligible for Medicaid coverage of LTC services.

Even during the penalty period, the individual still remains eligible for all other Medicaid services and could have payment made for services not subject to the penalty (e.g., physician services and prescriptions). The calculation of the penalty period imposed would not be affected under this Demonstration project, but the imposition of the penalty would impact those who have used estate planning to circumvent the transfer of asset rules. Maintaining the current scope of the transfer of asset penalty would allow clients to receive other vital medical services, while only delaying Medicaid coverage for LTC services.

B. Look-back Periods

Currently, when an individual applies for Medicaid, all the assets of the individual, except for certain trusts, are reviewed for transfers during the 36-month look-back period preceding the date the application is filed.

Under the Demonstration project, the look-back period would be extended from 36 months to 60 months for certain real property transfers that are not exempt or excepted under the rules (e.g., transfer of a home and title to a spouse). Transfers of real property, unlike other types of transfers, are easier to trace by supporting documentation and are generally significant in terms of dollar value. As a result, extending the look-back period for transfers involving real property to 60 months should result in the discovery of additional transfer activity that could be subject to penalty under this Demonstration. The look-back period for certain types of trusts currently subject to a 60-month look-back period would not change under this Demonstration project.

C. Thresholds

One potential drawback of delaying a penalty period for transferring assets when an individual is otherwise eligible for Medicaid payment of LTC services is that individuals could be penalized

for small, inexplicable transfers made years before application for Medicaid coverage. Additionally, the researching of smaller transfers on the part of the DSS, as well as complying with the verification requirements on the part of applicants and their families, could be very burdensome. Using threshold amounts in deciding whether or not transactions would result in a penalty period addresses this problem.

Threshold levels would be used to determine whether asset transfers for less than FMV would contribute to a penalty period. This change is not intended to alter which assets are reviewed, but rather to identify more significant uncompensated transfers and streamline the process by setting threshold levels those transfers must exceed before contributing to a penalty period assessment. If the total uncompensated value of an asset transferred for less than FMV does not exceed the threshold level applicable to that stage of the look-back, these transfers are disregarded and not reviewed any further. If the total amount of improper transactions exceed the threshold amount, a prospective penalty would be imposed based on the uncompensated value of the transfers.

The State proposes to incorporate the following threshold levels with this waiver:

1. $0 for transfers made less than 1 year preceding Medicaid application for LTC;
2. $2,500 for transfers made between 1 year and 2 years preceding Medicaid application for LTC; and
3. $5,000 for transfers made between year 2 and year 5 preceding Medicaid application for LTC.

To illustrate the use of these thresholds, assume that an individual applying for Medicaid LTC services has four separate $500 withdrawals in his bank records from 18 months prior to his application for LTC, and a single $1,000 withdrawal 6 months preceding the application. The average cost of private nursing facility care in the State is $6,779 per month. If no thresholds were used, a penalty period of almost 2 weeks ($3,100/$6,779 = .46 month) would be assessed beginning in the month the person would otherwise be eligible for Medicaid LTC services. However, by incorporating the above threshold levels, the four separate $500 withdrawals (totaling $2,000) do not exceed the $2,500 threshold level for the 1-year to 2-year look-back level. Thus, no penalty period would be assessed and the individual would not need to provide documentation for these transfers. On the contrary, the single $1,100 withdrawal does exceed the $0 threshold applicable to the less than 1-year look-back level and would result in a penalty period of approximately 5 days ($1,100/$6,779 = 0.16 month). Under the waiver, if the withdrawal were determined to be “improper,” the 5-day penalty period would be assessed beginning on the day the individual would otherwise be eligible for Medicaid coverage of LTC services.

With threshold levels, the State believes that focusing its attention on larger transfers would reduce its administrative time and expenses. More importantly, threshold levels would eliminate the burden on applicants and their families to produce documentation concerning relatively modest transactions and, thus, would make the Medicaid program more accommodating and efficient.

D. Due Process

Satisfactory Showing: The general rule is that a penalty for transferring an asset for less than FMV is not assessed if a "satisfactory showing" is made to the State that:

1. the individual **intended** to dispose of the assets either at FMV or for other valuable consideration;
2. the assets were transferred exclusively for a purpose other than to qualify for Medicaid;
3. all of the assets transferred have been returned to the individual; or
4. imposition of a penalty would cause an **undue hardship** on the individual as explained below.

The State would determine what constitutes a "satisfactory showing" for purposes of not imposing a penalty until such time that uniform federal guidelines are created. In general, "verbal assurances" are not enough and written documentation is needed in most cases, especially for those areas where the State has to make a decision regarding the "intent" of the individual.

Exempted Transfers: Transfers for the sole benefit of a spouse, child, or disabled individual must be accomplished via a written instrument that clearly sets out who could benefit from the transfer and include the following:

1. A home and its title when transferred to:
   a. the spouse;
   b. a child under age 21;
   c. a child who is blind or totally/permanently disabled;
   d. a sibling of the individual who
      i. has an equity interest in the house, or
      ii. has resided in the home for at least 1 year immediately prior to date individual was institutionalized; or
   e. a child over age 21 who
      i. resided in the home at least 2 years prior to the date the individual was institutionalized, and
      ii. provided care to the individual that permitted the individual to reside at home rather than an institution.
2. Any asset, including income or resources
   a. transferred to a spouse or another for the sole benefit of the spouse;
   b. transferred from the spouse to another for the sole benefit of the spouse;
   c. transferred to the individual's child who is blind or totally disabled, solely for the benefit of the child; or
   d. transferred to a trust established for the sole benefit of an individual under age 65 who is disabled.

Undue Hardship: A transfer of asset penalty is not imposed if the penalty would result in an undue hardship to the transferor. Connecticut's current undue hardship regulations require that the transferor be faced with the loss of long-term care service and demonstrate that the transferee does not have assets that could be used to pay for long-term care services.

The Department recognizes that individuals with dementia, as well as those who have been exploited, may be more vulnerable to the imposition of transfer of asset penalties under the

waiver. In response to this concern, the Department has proposed separate legislation that will enable us to provide additional protections for these individuals under the waiver. This legislation will allow the recovery of medical assistance benefits from individuals who received improperly transferred assets. This recovery authority, in turn, will allow the Department to eliminate the requirement that transferors demonstrate that transferees do not have assets that could be used to pay for long-term care services when the transferor has dementia or has been exploited. These expanded undue hardship provisions will also protect nursing facilities that rely on Medicaid payments.

Section 3
Organization and Administration

This Demonstration project would be administered by the DSS, the single State Medicaid agency. This section describes the organizational structure of Connecticut Medicaid and the timeline and work plan for the Demonstration project.

I. DEPARTMENT OF SOCIAL SERVICES ORGANIZATIONAL STRUCTURE

The DSS, the single State Medicaid Agency, is an umbrella agency that encompasses all of the Divisions with responsibility for components of the total Medicaid Program.

The DSS provides a broad range of services to elderly persons, disabled persons, families, and individuals that need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers more than 90 legislatively authorized programs and makes up approximately one-third of the State budget. By statute, it is the State Agency responsible for administering human service programs sponsored by federal legislation, including the Rehabilitation Act, the Food Stamp Act, the Older Americans Act, and the Social Security Act.

The Commissioner, along with the Deputy Commissioner of Programs and the Deputy Commissioner of Administration (including Medical Care Administration), are responsible for the administration of DSS. Regional Administrators manage the five service regions. Directors or other managers reporting to one of the three Commissioners manage nineteen organizational units within the central office. The Connecticut General Statutes require a Statewide advisory council to the Commissioner, and a regional advisory council in each region.

The DSS provides services through fifteen offices located in the five regions. Central office support is located in Hartford. The Commission on Aging, the Commission on Deaf and Hearing Impaired, the Board of Education Services for the Blind, and the Child Day Care Council are attached to the DSS for administrative purposes only.

The lead division for this Demonstration project is the Medical Care Administration whose constituency includes the target population.

A. Key Personnel:
The following is a list of the key personnel who would be involved in the implementation and operation of the Demonstration project:

1. **Patricia A. Wilson-Coker,** Commissioner
2. **Rita M. Pacheco,** Deputy Commissioner for Programs

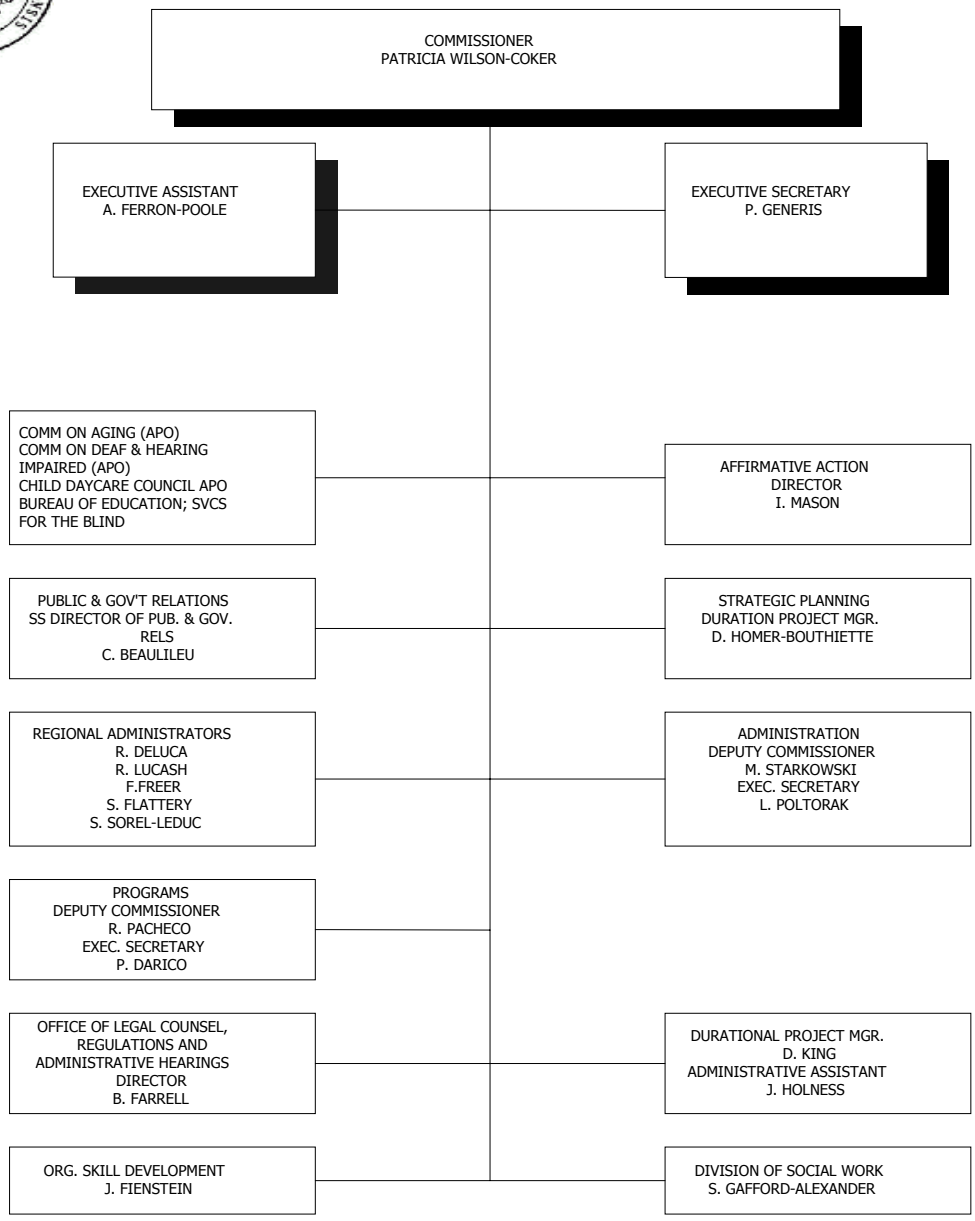
3. **Pamela A. Giannini,** Director, Adult Services Division
4. **Jocelyne Watrous,** Program Administration Manager, Adult Support
5. **Ronald DeLuca**, Regional Administrator (Eastern Region)
6. **Robert Lucash**, Regional Administrator (South Central Region)
7. **Frances Freer,** Regional Administrator (Southwest Region)
8. **Silvana Flattery,** Regional Administrator (North Central Region)
9. **Sandee Sorel-Leduc,** Regional Administrator (Northwest Region)

B. Functional Responsibilities:
The following section describes who would be responsible for the key functions that need to be conducted under the proposed Demonstration project.

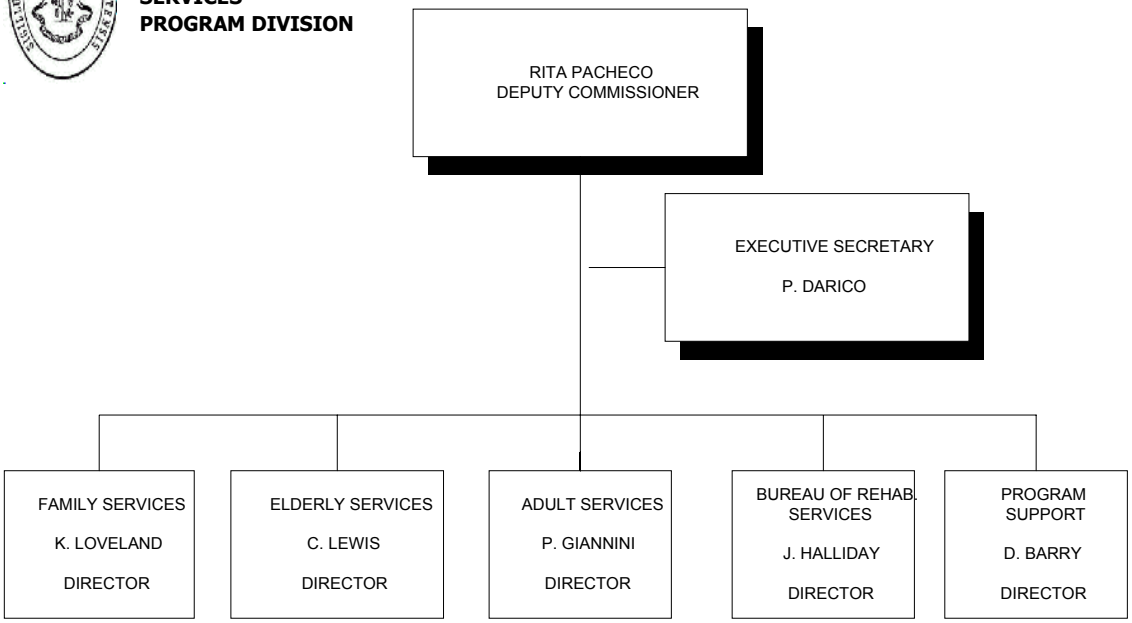
1. Policy Development: The Adult Support Unit within the Adult Services Division would develop regulations (program policy) that describe revised transfer of asset rules developed pursuant to the Demonstration project. This unit would also develop and operationalize written guidelines (procedures) for staff to follow in administering the new policy. Both policy and procedures would be published in the Department's Uniform Policy Manual.
2. Eligibility: Eligibility for Medicaid LTC is determined by Eligibility Service Workers in 15 DSS regional offices. These staff would review asset transfers as part of the normal Medicaid application process and would determine eligibility, or application of appropriate transfer penalties, based on revised transfer of asset rules developed pursuant to the Demonstration project. Adult Support staff would provide technical support to eligibility staff in the regions as required.
3. Grievance and Appeals: Applicants and recipients aggrieved by any agency decisions made pursuant to application of the new Demonstration project rules may appeal to the Department's Office of Legal Services, Regulations and Administrative Hearings, which conducts all administrative hearings for the Department. Applicants and recipients aggrieved by a hearing decision may appeal to the Superior Court.
4. Demonstration Reviews: The Adult Support Unit would conduct periodic reviews of transfer activity and the purchase of Long Term Care Partnership policies to measure both the fiscal impact and change in behavior attributable to the Demonstration project. In conducting these reviews and compiling information, the Adult Support Unit would work with the agency's MIS and Fiscal Analysis divisions, and another state agency (the Office of Policy and Management) that administers the Long Term Care Partnership program.
5. Reporting: The Adult Support Unit would be responsible for all reporting under the Demonstration project.

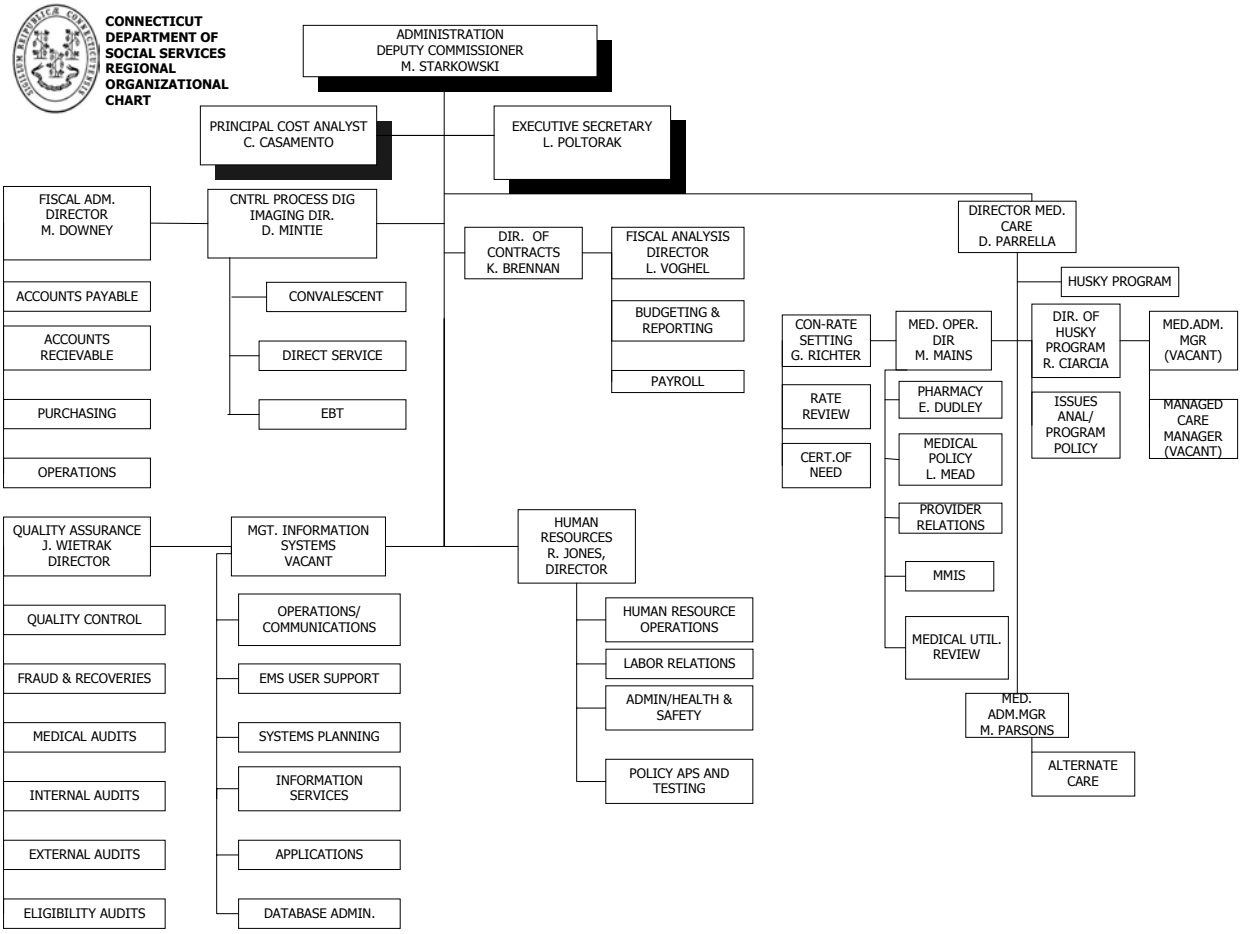
II. Organizational Charts

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
REGIONAL ORGANIZATIONAL CHART



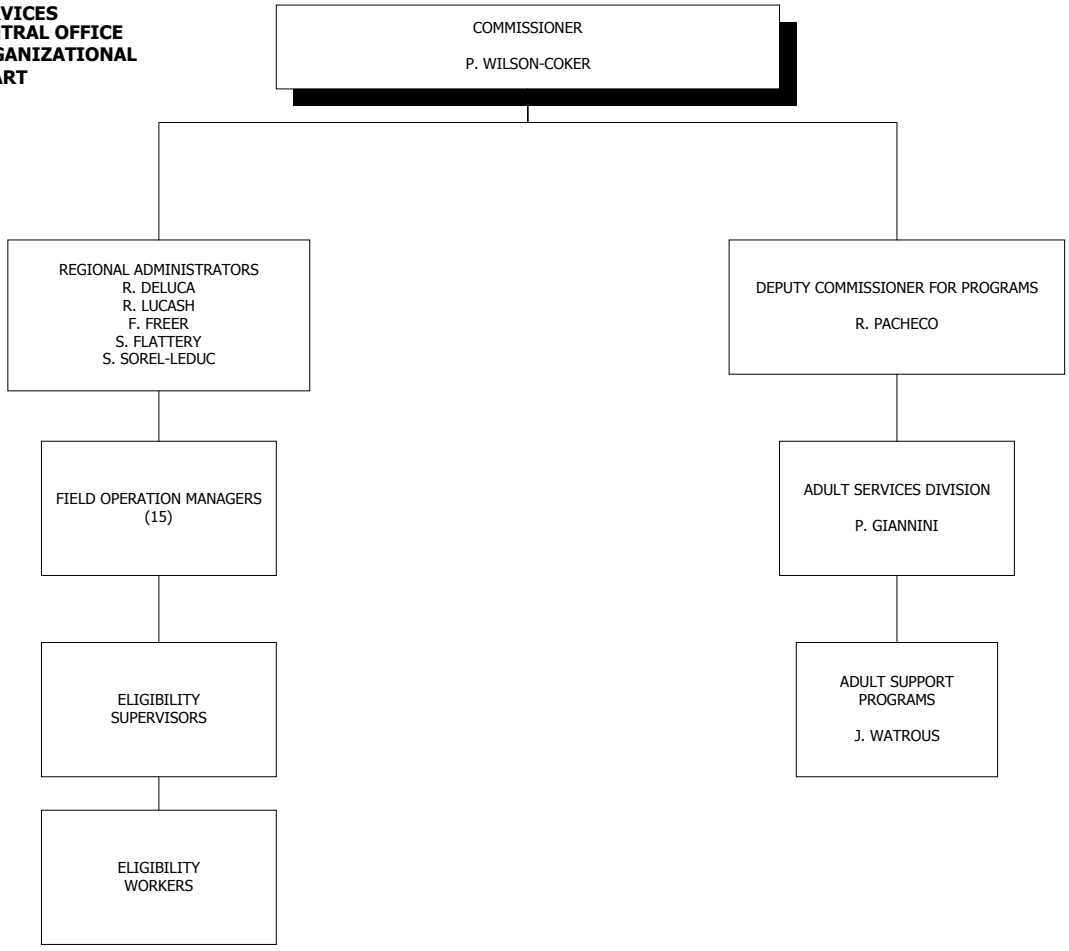
CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
PROGRAM DIVISION




CONNECTICUT
DEPARTMENT OF
SOCIAL SERVICES
REGIONAL
ORGANIZATIONAL
CHART
ADMINISTRATION
DEPUTY COMMISSIONER
M. STARKOWSKI
PRINCIPAL COST ANALYST
C. CASAMENTO
EXECUTIVE SECRETARY
L. POLTORAK
FISCAL ADM.
DIRECTOR
M. DOWNEY
CNTRL PROCESS DIG
IMAGING DIR.
D. MINTIE
DIR. OF
CONTRACTS
K. BRENNAN
FISCAL ANALYSIS
DIRECTOR
L. VOGHEL
DIRECTOR MED.
CARE
D. PARRELLA
ACCOUNTS PAYABLE
CONVALESCENT
BUDGETING &
REPORTING
HUSKY PROGRAM
ACCOUNTS
RECIEVABLE
DIRECT SERVICE
PAYROLL
CON-RATE
SETTING
G. RICHTER
MED. OPER.
DIR
M. MAINS
DIR. OF
HUSKY
PROGRAM
R. CIARCIA
MED.ADM.
MGR
(VACANT)
PURCHASING
EBT
RATE
REVIEW
PHARMACY
E. DUDLEY
ISSUES
ANAL/
PROGRAM
POLICY
MANAGED
CARE
MANAGER
(VACANT)
OPERATIONS
CERT.OF
NEED
MEDICAL
POLICY
L. MEAD
QUALITY ASSURANCE
J. WIETRAK
DIRECTOR
MGT. INFORMATION
SYSTEMS
VACANT
HUMAN
RESOURCES
R. JONES,
DIRECTOR
PROVIDER
RELATIONS
MMIS
QUALITY CONTROL
OPERATIONS/
COMMUNICATIONS
HUMAN RESOURCE
OPERATIONS
MEDICAL UTIL.
REVIEW
FRAUD & RECOVERIES
EMS USER SUPPORT
LABOR RELATIONS
MED.
ADM.MGR
M. PARSONS
MEDICAL AUDITS
SYSTEMS PLANNING
ADMIN/HEALTH &
SAFETY
INTERNAL AUDITS
INFORMATION
SERVICES
POLICY APS AND
TESTING
ALTERNATE
CARE
EXTERNAL AUDITS
APPLICATIONS
ELIGIBILITY AUDITS
DATABASE ADMIN.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES CENTRAL OFFICE ORGANIZATIONAL CHART

TRANSFER OF ASSET WAIVER SUPPORT



III. Time Lines

Task	Date
Public notice of the Demonstration proposal published in the Connecticut Law Journal (CLJ) for public comment	12-18-01
Demonstration proposal submitted to CMS for informal review and feedback	TBD
Formal Demonstration proposal submitted to CMS	TBD
Operational protocols submitted to CMS for approval	TBD
Implementation of the Demonstration project	10-01-02

Section 4
Evaluation

A. Demonstration Objective

The objective of this Demonstration is to discourage large transfers of wealth for the purposes of qualifying for Medicaid payment of LTC services. This section presents a plan to analyze the impact of changing the imposition of penalty periods, implementing thresholds, and extending the look-back period to 60 months for real property transfers that are not exempt or excepted under the rules.

B. Suggested Research Hypotheses for the Demonstration

The principal research hypotheses are:

1. The design of the Demonstration would cause a shift in the spenddown behavior of Demonstration participants.
2. A change in the TOA policy would encourage the greater purchase of Long Term Care Partnership policies.
3. The implementation of thresholds would expedite the processing of applications and eligibility determinations.
4. The Demonstration would be cost effective to the State and to the federal government.
5. The Demonstration would guide the development of State and federal health care policy by including program changes to Medicaid.

C. Suggested Data Sources for the Evaluation

Several data sources could be used to test the research hypotheses:

1. **Sales Data from Connecticut Partnership Policies**
   Sales data could be analyzed to measure the demographics of the purchasers, amount of insurance coverage purchased, as well as whether the stricter TOA's policies correlate to an increase of Long Term Care Partnership policies sold in the State.
2. **Eligibility and Enrollment Data**
   Eligibility and enrollment Medicaid data could be analyzed to determine whether administrative thresholds expedite the processing of applications and eligibility determinations.

3. **Medicaid Management Information System (MMIS) Data**
   A review of the frequency and amount of improper transfers made both before and after implementation of the Demonstration project could be analyzed to determine whether the there is a shift in behavior of the Demonstration participants. Additionally, Medicaid LTC expenditures both before and after implementation of the Demonstration project could be analyzed to determine the value of savings (through cost avoidance) to Medicaid.

D. Suggested Plan for the Data Analysis

Using eligibility and enrollment information, along with the sales and other data just described above, the State could focus its analysis on the following questions:

1. How does a change in the penalty structure under the TOA rules, including changing the threshold levels and extending the look-back periods for real estate transfers affect the likelihood that the number of penalties being imposed would decrease?
2. How does a change in the penalty structure affect the likelihood that persons who would otherwise transfer assets instead purchase LTC insurance policies under the Long Term Care Partnership program in the State?
3. How does a change in the penalty structure, look-back periods, and thresholds realize savings (through cost avoidance) for the Medicaid program?

Section 5
Cost and Caseload

Although it could be said that the intent of the federal policy surrounding the application of the asset transfer penalty period was to treat all individuals equitably, it is clear that advanced planning could significantly nullify its intended purpose. It is likely that the current laws result in literally no penalty period actually being imposed for which Medicaid coverage of LTC services is denied. As a result, millions of dollars are shifted to public health programs that could otherwise have been used to purchase additional LTC insurance policies or simply fund privately obtained LTC services.

Through this Demonstration project, the State seeks approval to change the start date on which the penalty period begins for individuals that make certain types of asset transfers for less than FMV. As previously noted, the calculation of the penalty period would not change under the Demonstration project. The start date on which the penalty period begins would be changed to the date the individual would otherwise be eligible for Medicaid coverage of long-term care services. The State is also expanding the undue hardship provisions to include additional safeguards for individuals with dementia or individuals that have been exploited. These additional safeguards will benefit these individuals, as well as nursing facilities, by making Medicaid coverage of nursing facility care more readily obtainable.

Additionally, the State intends to incorporate threshold levels and modify the look-back periods to reduce the administrative time, streamline the process, and reduce the complexity associated with the Medicaid LTC program. More importantly though, threshold levels would eliminate the burden on applicants and their families to produce documentation concerning relatively modest transactions and, thus, would make the Medicaid program more accommodating.

The remaining parts of this section describe the State's approach to showing budget neutrality and the data and assumption used in the development of the cost and caseload estimates.

A. Waiver Time Frame

The proposed Demonstration project program would begin on October 1, 2002, subject to CMS approval, and conclude on September 30, 2007. The five-year term of the Demonstration project, thus, covers federal fiscal years 2003 through 2007 (FFY03 through FFY07).

Data was available from FFY92 through FFY97 including a specific data extract from calendar year 2000 to support the development of cost and caseload projections. FFY97 was chosen as the base year throughout the cost and caseload projections. More recent data from 1998 through 2000 was used for trending purposes.

B. Budget Neutrality Approach

Since this Demonstration project is designed to change the start date on which the penalty period begins for certain asset transfers made at less than FMV, there is essentially no new cost being incurred within the Medicaid program. In fact, changing the start date to the day on which a person would otherwise be eligible for Medicaid coverage of LTC services reduces the cost to the Medicaid program. The test of budget neutrality involves comparing expenditures assuming this Demonstration project is approved (i.e., with waiver) to expenditures if the Demonstration project is disallowed (i.e., without waiver).

The tables included in Appendix A document budget neutrality by presenting data on the two main groups of individuals whose behavior is expected to be modified through this Medicaid waiver. These two groups are briefly described below:

- NH Institutional Population: This group represents those that obtain Medicaid coverage of nursing homes/facilities services through the Medicaid LTC system. The costs to the Medicaid program for people in nursing facilities is substantially higher than for those served in non-institutionalized settings.
- HCB Non-Institutionalized Population: This group includes all individuals receiving Medicaid funded home- and community-based (HCB) services in lieu of institutional care. This group requires the level-of-care provided by a nursing facility, but has elected to receive services in the community and, thus, have substantially lower overall costs.

C. Caseload Estimates

Not everyone who obtains Medicaid coverage of LTC services does so by making asset transfers. Furthermore, an even smaller number do the type of asset transfers at less than FMV with the sole intent of qualifying for Medicaid eligibility, which could otherwise be used to fund privately obtained LTC. Notwithstanding this, even the few remaining applicants still create substantial costs to the Medicaid program. In conjunction with this Demonstration project, it is the State's goal to modify the behavior of our citizens to both reduce the cost to the Medicaid program and to encourage more personal needs planning through such things as LTC insurance policies. The State anticipates that through the combination of additional insurers paying for nursing care and the additional undue hardship safeguards for dementia and exploitation, those in need will not be unduly penalized nor will there be an incentive for nursing facilities to discharge individuals to hospitals.

1. Without Waiver Caseload

In the absence of CMS granting approval for our Demonstration project request, the State must continue to follow existing federal policy regarding TOA. As previously mentioned, these existing policies do little to encourage personal responsibility, but instead, promote the shifting of wealth to third parties. This practice is inconsistent with the intent of Medicaid being the payor of last resort.

In developing our without waiver caseload we realized early on that, as a matter of practicality, few if any individuals were impacted by the current federal policies on TOA. This was not entirely surprising, but it was discouraging to realize the results of current behaviors and practice patterns. Based on a review of the State's historical eligibility/enrollment data for Medicaid funded nursing facilities and HCB programs, we estimated the number of people entering the LTC system. This population served as the without waiver caseload. In the base year of FFY97, the data showed that there were 4,937 nursing facility applicants and 1,221 HCB program applicants. It has already been noted that not all people would have asset transfers subject to penalty. Indeed, an analysis performed on a sample of 300 LTC applicants determined that 36% of the NH and 35% of the HCB program applicants contained asset transfers with improper transfer activity. We believe it is a reasonable assumption that these percentages would remain constant. Furthermore, the historical trend in the number of NH and HCB program entries was reviewed and projected to support the development of the without waiver caseload. The following table summarizes the trend rate, transfer rate, and overall caseload for both the NH and HCB program populations for the five-year Demonstration period:

Without Waiver NH Institutional Population Caseload

Waiver Year	1	2	3	4	5
NH-Enrollment Trend	1.5%	1.0%	1.0%	1.0%	1.0%
NH-Total Applicants	4,867	4,916	4,965	5,015	5,065
NH-Percent with Transfers	36%	36%	36%	36%	36%
NH-People with Transfers	1,752	1,770	1,787	1,805	1,823

Without Waiver HCB Non-Institutionalized Population Caseload

Waiver Year	1	2	3	4	5
HCB-Enrollment Trend	10.0%	10.0%	10.0%	10.0%	10.0%
HCB-Total Applicants	2,976	3,273	3,600	3,960	4,356
HCB-Percent with Transfer	35%	35%	35%	35%	35%
HCB-People with Transfer	1,041	1,146	1,260	1,386	1,525

Although the above tables demonstrate that there are individuals who have asset transfers that could have resulted in a penalty period being assessed, a review of the State's data showed that, in terms of Medicaid denying coverage for either nursing facilities or HCB program waiver services, there was virtually no penalty time actually being served. This conclusion was used in the development of our without waiver cost projections.

2. With Waiver Caseload

In contrast to the without waiver scenario, the State intends to modify the behavior of its citizens to encourage more personal responsibility through such things as purchasing LTC insurance. By no means does the State intend to "punish" any citizen; this is why we make it clear that all provisions related to transferring assets to certain family members (e.g., spouse, disabled child for the sole purpose of benefiting the spouse or child) and in cases where the provisions would cause an undue hardship, including the expanded protections for individuals with dementia or who have been exploited, are retained with our Demonstration project. Furthermore, the State

intends to streamline the TOA process by incorporating the threshold levels and look-back periods previously discussed.

Based on the with waiver criteria, we estimated the caseload for our with waiver projections. Starting with our base year (FFY97) figures, we estimated the impact that our waiver would have on those in nursing facilities and those receiving services through HCB programs. For the purpose of determining the with waiver caseload projections we assumed the same trend and transfer rate as that used in the without waiver projections.

D. Cost Estimates

1. Without Waiver Cost Estimates

In the development of the without waiver expenditure estimates, the State is showing the cost associated with the Medicaid program for individuals that enter Medicaid's LTC program through nursing homes/facilities and HCB programs. Federal law requires the State to deny coverage for certain Medicaid covered services to otherwise eligible individuals who make improper asset transfers at less than FMV. Accordingly, for the purposes of this Demonstration project, the State analyzed historical Medicaid claims data specifically on the cost of providing NH care and HCB waiver-specific services only. Thus, during an individual's penalty period, the services that the State would deny coverage for are the cost of the nursing facility and the cost of the specific HCB waiver-only services.

Our analysis of historical claims data revealed that the average monthly cost of a nursing facility under the Medicaid program was $2,860 per member per month (PMPM) during the base year (FFY97). In contrast, HCB programs are designed to keep individuals out of costly institutions by providing supplemental services to enable individuals to remain at home (i.e., in the community). As a result, the average monthly cost per person for HCB waiver services only was $634 in FFY97. The NH PMPM was trended to Year 1 of the Demonstration (FFY03) using annual trend rates ranging from 2.0% to 3.8%. The HCB PMPM was trended to Year 1 using annual trend rates ranging from 2.5% to 4.2%. For the subsequent years of the Demonstration, the annual NH trend rates used were 3.8% and 4.2% for NH and HCB, respectively.

Using these PMPMs, trends, and the estimated number of people in nursing facilities and HCB programs, we projected the total Medicaid cost for the five years of the Demonstration. The following tables display the without waiver projected costs:

Without Waiver NH Institutional Population Estimated Costs

Waiver Year	1	2	3	4	5
Member Months	269,492	272,187	274,909	277,658	280,435
PMPM	$3,444	$3,575	$3,711	$3,852	$3,998
Cost (In 000s)	$928,125	$973,027	$1,020,102	$1,069,455	$1,121,195

Without Waiver HCB Non-Institutionalized Population Estimated Costs

Waiver Year	1	2	3	4	5
Member Months	148,619	163,481	179,830	197,813	217,594
PMPM	$784	$817	$851	$887	$924
Cost (In 000s)	$116,549	$133,589	$153,119	$175,505	$201,164

In the above tables, the number of member months were derived by multiplying the number of NH and HCB program applicants by 12. Even though some individuals would incur a penalty under the without waiver scenario, as demonstrated in the caseload figures, for the purposes of the without waiver cost projections, the State estimated that zero months of penalty were actually served for which Medicaid coverage of LTC services was denied. Therefore, the without waiver cost projections were calculated by multiplying the number of applicants by 12 (member months) and then multiplying this number by the average PMPM for nursing facilities and HCB waiver services, respectively.

2. With Waiver Cost Estimates

For the with waiver expenditure estimates, the State is again showing the cost associated with the Medicaid program for individuals that enter Medicaid's LTC program through nursing homes/facilities and HCB programs. We again considered only the Medicaid cost associated with the services, which would be denied: the cost of the nursing facility and the cost of the specific HCB waiver-only services, for the with waiver cost projections.

Since this Demonstration project is designed to modify behavior over time by encouraging individuals to provide more of their own LTC needs (by changing the penalty start date), we used the same base year PMPMs of $2,860 and $634 for nursing facility and HCB programs, respectively, and the same annual trends for the with waiver cost projections as the without waiver cost projections.

To determine the amount of funds an individual could apply towards providing their own LTC needs, the State reviewed a random sample of Medicaid LTC applications. Using the criteria included in this Demonstration project request (threshold levels and look-back periods), it was determined that the average amount of improper transfer activity was $32,661 and $27,365 for NH and HCB program applicants, respectively. These values were trended to year 1 of the Demonstration project (FFY03) at annual rate of 5.0% to reflect an average rate of return, resulting in year 1 values of $37,809 and $31,678 for NH and HCB, respectively.

Since this Demonstration project only applies to transfers made on or after the implementation date (October 1, 2002), we assumed that not all of the average transfer value would be available to the individual in the first year of the Demonstration project. Thus, the Medicaid program would experience a relatively modest amount of savings in the first year. However, in subsequent years of the Demonstration project, individuals would increasingly have a larger percentage of estimated transferred asset value to apply towards their own LTC needs. We assumed that the maximum percentage of available funds (50%) would be achieved in Year 3 of the Demonstration project and then remain constant in the remaining Demonstration project years.

Since the basic premise of our Demonstration project is to change behavior, we anticipate that individuals would find other ways to discard assets and/or more likely produce documentation on recent transfers that would reduce the average total transfer amount that would be subject to penalty.

Notwithstanding the above, a direct result of modifying the behavior of our citizens in a manner that encourages more personal responsibility, is that the Medicaid program would cover fewer months of NH and HCB services. These savings were estimated using the process upon which the penalty period is calculated. Specifically, the State divided the average amount of funds assumed available to the number of people with transfer activity by the average cost of a privately funded nursing facility within the State of Connecticut. As a result, we were able to estimate the direct savings in the Medicaid program achieved as a result of this Demonstration project by modifying the behavior of our citizens without unduly penalizing individuals who have dementia or have been exploited. Additionally, DSS is proposing legislation that will allow for the possible recovery of Medicaid benefits from individuals who receive non-exempt asset transfers. This may result in a nominal increase in administrative costs.

The following table summarizes the total number of months for each population, which Medicaid would not cover under the Demonstration project using the with waiver caseload projections:

With Waiver NH Institutional Population Savings Months

Waiver Year	1	2	3	4	5
NH-People with Transfers	1,752	1,770	1,787	1,805	1,823
NH-Avg. Amount of Funds Used to Provide LTC Needs	$7,562	$15,880	$20,842	$21,884	$22,979
Avg. Private Pay Nursing Facility Rate	$7,167	$7,439	$7,722	$8,015	$8,320
NHC-Equivalent Months of Privately Funded LTC Per Person	1.1	2.1	2.7	2.7	2.8
NH-Total Months Not Paid By Medicaid	1,849	3,778	4,825	4,929	5,036

With Waiver HCB Non-Institutionalized Population Savings Months

Waiver Year	1	2	3	4	5
HCB-People with a Penalty	1,041	1,146	1,260	1,386	1,525
HCB-Avg Amount of Funds Used to Provide LTC Needs	$6,336	$13,305	$17,463	$18,336	$19,253
Avg. Private Pay Nursing Facility Rate	$7,167	$7,439	$7,722	$8,015	$8,320
HCB- Equivalent Months of Privately Funded LTC	0.9	1.8	2.3	2.3	2.3
HCB-Total Months Not Paid By Medicaid	921	2,049	2,850	3,171	3,528

The total number of months not paid by Medicaid effectively reduces the total number of Medicaid covered months and, thus, the cost to the Medicaid program. The following tables

summarize the estimated with waiver Medicaid costs based on the premise that Medicaid would not cover the cost of nursing facilities nor HCB waiver services for the total number of months note above:

With Waiver NH Institutional Population Estimated Medicaid Costs

Waiver Year	1	2	3	4	5
Member Months	267,643	268,409	270,084	272,729	275,398
PMPM	$3,444	$3,575	$3,711	$3,852	$3,998
Cost (In 000s)	$921,757	$959,522	$1,002,200	$1,050,469	$1,101,061

With Waiver HCB Non-Institutionalized Population Estimated Medicaid Costs

Waiver Year	1	2	3	4	5
Member Months	147,699	161,432	176,980	194,641	214,065
PMPM	$784	$817	$851	$887	$924
Cost (In 000s)	$115,827	$131,914	$150,693	$172,692	$197,902

E. Summary of Cost Effectiveness

For this Demonstration project, total combined Medicaid expenditures for both population groups would not exceed what total Medicaid expenditures would be without the waiver. The savings attributable to this Demonstration project would be realized by encouraging personal responsibility through changing the start date on which the penalty period for improper asset transfers made at less than FMV begins from the month in which the asset transfer occurred to the day on which an individual is otherwise eligible for Medicaid covered LTC. As shown in the table below, total projected Medicaid expenditures with the waiver are less than the total projected Medicaid expenditures without the waiver. Therefore, our TOA waiver satisfies the budget neutrality test.

With Waiver	Without Waiver	Savings
$5,804,036,952	$5,891,831,777	$87,794,826

Section 6
Waivers Requested

This Demonstration project requires waivers from Title XIX of the Social Security Act. Section 1115(a)(1) of the Social Security Act permits the Secretary of the Department of Health and Human Services (the Secretary) to waive compliance with any of the requirements of Section 1902 of the Social Security Act, which specifies State Medicaid Plan requirements, to the extent and for the period necessary to carry out the Demonstration project. Section 1115(a)(2) permits Connecticut to regard as expenditures under the State plan, costs of the Demonstration project that would not otherwise receive a federal match under section 1903 of the Social Security Act. These provisions allow the Secretary to waive existing program restrictions and provide expanded eligibility and/or services to individuals not otherwise covered by Medicaid. Connecticut requests that the Secretary waive the following Title XIX provisions:

Title 42, Chapter 7, Subchapter XIX, Sec. 1396p. Liens, adjustments and recoveries and transfers of assets (cite as 42 USC Sec. 1396p).

General: Under 1396p(c)(4), A State (including a State which has elected treatment under section 1396a (f) of this title) may not provide for any period of ineligibility for an individual due to a transfer of resources for less than fair market value except in accordance with this subsection. *A waiver of this provision is required so that the State could impose longer look-back periods for transfers of real property, toll the penalty period from the date of eligibility for Medicaid LTC services, and reinstate eligibility for transferred assets that are returned to the individual.*

Look-back periods: Under 1396p(c)(1)(B)(i), the look-back date specified is 36 months (or in the case of payments from a trust or portions of a trust that are treated as assets disposed by the individual, 60 months) before the date an institutionalized individual has applied for medical assistance under the State plan or a non-institutionalized individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value. *A waiver of this provision is required to permit the State to look-back 60 months for transfers of real property not exempt or excepted under the law.*

Penalty period start date: Section 1396p(c)(1)(D), specifies the date in which a penalty period is assessed for individuals who have transferred assets during the look-back period for less than fair market value. The date specified is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other period of ineligibility under this subsection. *A waiver of this provision is required so that the penalty period would be assessed on the first day in which Medicaid eligibility of LTC services is established.*

Thresholds: Section 1396p(c)(1)(E)(i) and (ii), specifies that the penalty assessed would be determined for both institutionalized individuals and non-institutionalized individuals by taking the total, cumulative uncompensated value of all assets transferred by the individual divided by the average monthly cost to a private patient of nursing facility services in the State at the time of application. *A waiver of this provision is required so that threshold amounts would determine whether asset transfers would contribute to a penalty period. If the total amount of uncompensated asset transfers (i.e., impermissible transfers) does not exceed the threshold level applicable to that stage of the look-back, these transfers are disregarded.*

Expenditures. In addition, the State requests, under the authority of Section 1115 (a)(2), that the following expenditures for the Demonstration (which are not otherwise included as expenditures under Section 1903) shall, for the Demonstration period, be regarded as expenditures under the State's Medicaid State Plan:

1. expenditures that would otherwise be precluded by Section 1903(f) for all Demonstration participants; and
2. any and all Administrative expenditures related to the implementation of this Demonstration project.

Other Provisions. The State requests that the Secretary grant any other waiver deemed necessary in order to implement the Demonstration project described herein.

Appendix A
Medicaid Budget Neutrality

Table A-1

Funding Analysis (FFY03-FFY07)

	Federal Medicaid Expenditures (in Thousands)	**State Medicaid Expenditures** (in Thousands)	**Total Expenditures** (in Thousands)
Total Waiver Program			
Without Waiver Scenario	$ 2,945,916	$ 2,945,916	$ 5,891,832
With Waiver Scenario	$ 2,902,018	$ 2,902,018	$ 5,804,037
Waiver Impact - Savings/(Cost)	$ 43,897	$ 43,897	$ 87,795
Administration - Savings/(Cost)	$ 271	$ 271	$ 542

Table A-2

Total Waiver Program (FFY03-FFY07)

	Medicaid Expenditures (in Thousands)
Nursing Home Population	
Without Waiver Scenario	$ 5,111,905
With Waiver Scenario	$ 5,035,008
HCBS Population	
Without Waiver Scenario	$ 779,927
With Waiver Scenario	$ 769,029
Total - All Populations	
Without Waiver Scenario	$ 5,891,832
With Waiver Scenario	$ 5,804,037

Table A-3

Enrollment Projection: Total With Waiver Program (FFY03-FFY07)

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Population (Member Months)					
Nursing Home Population	267,643	268,409	270,084	272,729	275,398
HCBS Population	147,699	161,432	176,980	194,641	214,065
Total - All Populations	415,342	429,842	447,064	467,370	489,464

STATE OF CONNECTICUT **Transfer of Assets Waiver**

Table A-4

***Without* Waiver**
Assumptions

The following assumptions have been made:

1. Trend

	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population										
Member Months	-3.50%	-4.50%	1.00%	2.30%	2.00%	1.50%	1.00%	1.00%	1.00%	1.00%
Medicaid PMPM	2.00%	2.50%	3.00%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%
HCBS Population										
Member Months	46.77%	13.00%	10.35%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%
Medicaid PMPM	2.50%	3.00%	3.50%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%

2. Caseload Projections (Number of Eligibles)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Nursing Home Population	22,458	22,682	22,909	23,138	23,370	114,557
HCBS Population	12,385	13,623	14,986	16,484	18,133	75,611
Total	34,843	36,306	37,895	39,623	41,502	190,168

Table A-5

***Without* Waiver**
Member Months

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	**FFY94**	**FFY95**	**FFY96**	**FFY97**	**FFY98**	**FFY99**	**FFY00**	**FFY01**	**FFY02**	**FFY03**	**FFY04**	**FFY05**	**FFY06**	**FFY07**
Nursing Home Population															
Total Member Months	263,672	273,905	282,757	277,493	273,371	263,803	251,932	254,451	260,303	265,509	269,492	272,187	274,909	277,658	280,435
HCBS Population															
Total Member Months	29,019	40,181	52,661	54,966	61,010	89,544	101,184	111,660	122,826	135,109	148,619	163,481	179,830	197,813	217,594
Total - All Populations															
Total Member Months	292,691	314,086	335,418	332,459	334,381	353,347	353,116	366,111	383,129	400,618	418,112	435,668	454,738	475,470	498,028

Table A-6

***Without* Waiver**
Cost Exhibit

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	FFY94	FFY95	FFY96	FFY97	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population															
Medicaid PMPM	$ 2,790	$ 2,863	$ 2,946	$ 2,819	$ 2,860	$ 2,917	$ 2,990	$ 3,079	$ 3,196	$ 3,318	$ 3,444	$ 3,575	$ 3,711	$ 3,852	$ 3,998
HCBS Population															
Medicaid PMPM	$ 596	$ 602	$ 627	$ 645	$ 634	$ 650	$ 670	$ 693	$ 722	$ 753	$ 784	$ 817	$ 851	$ 887	$ 924
Total - All Populations															
Medicaid PMPM	$ 2,573	$ 2,574	$ 2,582	$ 2,459	$ 2,454	$ 2,342	$ 2,325	$ 2,352	$ 2,403	$ 2,453	$ 2,499	$ 2,540	$ 2,580	$ 2,618	$ 2,655

Table A-7

***Without* Waiver**
Cost Summary

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	FFY94	FFY95	FFY96	FFY97	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population															
PMPM	$ 2,790	$ 2,863	$ 2,946	$ 2,819	$ 2,860	$ 2,917	$ 2,990	$ 3,079	$ 3,196	$ 3,318	$ 3,444	$ 3,575	$ 3,711	$ 3,852	$ 3,998
Targeted Member Months	263,672	273,905	282,757	277,493	273,371	263,803	251,932	254,451	260,303	265,509	269,492	272,187	274,909	277,658	280,435
Total $	$ 735,666,912	$ 784,151,105	$ 832,995,714	$ 782,180,545	$ 781,734,824	$ 769,461,543	$ 753,207,072	$ 783,560,331	$ 832,042,343	$ 880,933,151	$ 928,124,740	$ 973,027,415	$ 1,020,102,481	$ 1,069,455,040	$ 1,121,195,274
HCBS Population															
PMPM	$ 596	$ 602	$ 627	$ 645	$ 634	$ 650	$ 670	$ 693	$ 722	$ 753	$ 784	$ 817	$ 851	$ 887	$ 924
Targeted Member Months	29,019	40,181	52,661	54,966	61,010	89,544	101,184	111,660	122,826	135,109	148,619	163,481	179,830	197,813	217,594
Total $	$ 17,283,426	$ 24,205,436	$ 33,006,862	$ 35,480,003	$ 38,701,694	$ 58,222,292	$ 67,764,444	$ 77,397,692	$ 88,713,234	$ 101,683,109	$ 116,549,179	$ 133,588,669	$ 153,119,333	$ 175,505,379	$ 201,164,266
Total - All Populations															
PMPM	$ 2,573	$ 2,574	$ 2,582	$ 2,459	$ 2,454	$ 2,342	$ 2,325	$ 2,352	$ 2,403	$ 2,453	$ 2,499	$ 2,540	$ 2,580	$ 2,618	$ 2,655
Targeted Member Months	292,691	314,086	335,418	332,459	334,381	353,347	353,116	366,111	383,129	400,618	418,112	435,668	454,738	475,470	498,028
Total $	$ 752,950,338	$ 808,356,541	$ 866,002,576	$ 817,660,549	$ 820,436,517	$ 827,683,835	$ 820,971,516	$ 860,958,023	$ 920,755,577	$ 982,616,260	$ 1,044,673,920	$ 1,106,616,085	$ 1,173,221,814	$ 1,244,960,419	$ 1,322,359,540

Table A-8

***With* Waiver**
Assumptions

The following assumptions have been made:

1. Trend

	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population										
Member Months	-3.50%	-4.50%	1.00%	2.30%	2.00%	0.80%	0.29%	0.62%	0.98%	0.98%
Medicaid PMPM	2.00%	2.50%	3.00%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%
HCBS Population										
Member Months	46.77%	13.00%	10.35%	10.00%	10.00%	9.32%	9.30%	9.63%	9.98%	9.98%
Medicaid PMPM	2.50%	3.00%	3.50%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%

2. Caseload Projections (Number of Eligibles)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Nursing Home Population	22,304	22,367	22,507	22,727	22,950	112,855
HCBS Population	12,308	13,453	14,748	16,220	17,839	74,568
Total	34,612	35,820	37,255	38,948	40,789	187,423

Table A-9

***With* Waiver**
Member Months

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	**FFY94**	**FFY95**	**FFY96**	**FFY97**	**FFY98**	**FFY99**	**FFY00**	**FFY01**	**FFY02**	**FFY03**	**FFY04**	**FFY05**	**FFY06**	**FFY07**
Nursing Home Population															
Total Member Months	263,672	273,905	282,757	277,493	273,371	263,803	251,932	254,451	260,303	265,509	267,643	268,409	270,084	272,729	275,398
HCBS Population															
Total Member Months	29,019	40,181	52,661	54,966	61,010	89,544	101,184	111,660	122,826	135,109	147,699	161,432	176,980	194,641	214,065
Total - All Populations															
Total Member Months	292,691	314,086	335,418	332,459	334,381	353,347	353,116	366,111	383,129	400,618	415,342	429,842	447,064	467,370	489,464

Table A-10

***With* Waiver**
Cost Exhibit

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	FFY94	FFY95	FFY96	FFY97	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population															
Medicaid PMPM	$ 2,790	$ 2,863	$ 2,946	$ 2,819	$ 2,860	$ 2,917	$ 2,990	$ 3,079	$ 3,196	$ 3,318	$ 3,444	$ 3,575	$ 3,711	$ 3,852	$ 3,998
HCBS Population															
Medicaid PMPM	$ 596	$ 602	$ 627	$ 645	$ 634	$ 650	$ 670	$ 693	$ 722	$ 753	$ 784	$ 817	$ 851	$ 887	$ 924
Total - All Populations															
Medicaid PMPM	$ 2,573	$ 2,574	$ 2,582	$ 2,459	$ 2,454	$ 2,342	$ 2,325	$ 2,352	$ 2,403	$ 2,453	$ 2,498	$ 2,539	$ 2,579	$ 2,617	$ 2,654

Table A-11

***With* Waiver**
Cost Summary

	Support Period				Base Period	Trend Period					Waiver Period				
	FFY93	FFY94	FFY95	FFY96	FFY97	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07
Nursing Home Population															
PMPM	$ 2,790	$ 2,863	$ 2,946	$ 2,819	$ 2,860	$ 2,917	$ 2,990	$ 3,079	$ 3,196	$ 3,318	$ 3,444	$ 3,575	$ 3,711	$ 3,852	$ 3,998
Targeted Member Months	263,672	273,905	282,757	277,493	273,371	263,803	251,932	254,451	260,303	265,509	267,643	268,409	270,084	272,729	275,398
Total $	$ 735,666,912	$ 784,151,105	$ 832,995,714	$ 782,180,545	$ 781,734,824	$ 769,461,543	$ 753,207,072	$ 783,560,331	$ 832,042,343	$ 880,933,151	$ 921,757,320	$ 959,522,117	$ 1,002,199,521	$ 1,050,468,950	$ 1,101,060,526
HCBS Population															
PMPM	$ 596	$ 602	$ 627	$ 645	$ 634	$ 650	$ 670	$ 693	$ 722	$ 753	$ 784	$ 817	$ 851	$ 887	$ 924
Targeted Member Months	29,019	40,181	52,661	54,966	61,010	89,544	101,184	111,660	122,826	135,109	147,699	161,432	176,980	194,641	214,065
Total $	$ 17,283,426	$ 24,205,436	$ 33,006,862	$ 35,480,003	$ 38,701,694	$ 58,222,292	$ 67,764,444	$ 77,397,692	$ 88,713,234	$ 101,683,109	$ 115,827,172	$ 131,914,405	$ 150,692,798	$ 172,691,932	$ 197,902,211
Total - All Populations															
PMPM	$ 2,573	$ 2,574	$ 2,582	$ 2,459	$ 2,454	$ 2,342	$ 2,325	$ 2,352	$ 2,403	$ 2,453	$ 2,498	$ 2,539	$ 2,579	$ 2,617	$ 2,654
Targeted Member Months	292,691	314,086	335,418	332,459	334,381	353,347	353,116	366,111	383,129	400,618	415,342	429,842	447,064	467,370	489,464
Total $	$ 752,950,338	$ 808,356,541	$ 866,002,576	$ 817,660,549	$ 820,436,517	$ 827,683,835	$ 820,971,516	$ 860,958,023	$ 920,755,577	$ 982,616,260	$ 1,037,584,492	$ 1,091,436,522	$ 1,152,892,319	$ 1,223,160,881	$ 1,298,962,738